NOTIFICATION OF VOCATIONAL SERVICES
by Private Rehabilitation Specialist

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://www.dwd.state.wi.us/wc/
e-mail: DWDDWC@dwd.state.wi.us

Return completed copy: One to insurance company (or self-insured employer) and one copy to Worker's Compensation Division.

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m)].

EMPLOYEE	WC Claim Number	Employee Name	
	Social Security Number	Employee Address (Number, Street, City, State, Zip Code)	
	Injury Date	Date of Birth	Telephone Number ( )
	Employer Name		
	Diagnosed Disability/Injury		
	Employee's Work Restrictions/Limitations		
INSURER	Insurance Company		
	Mailing Address (Number, Street, City, State, Zip Code)		
	Claim Representative	Telephone Number ( )	
VOCATIONAL REHABILITATION SPECIALIST	Name		
	WCD Certification Number	Telephone Number ( )	
	Agency Name		
	Mailing Address (Number, Street, City, State, Zip Code)		

Check Services Planned: ☐ Vocational Evaluation ☐ Job Placement

☐ Retraining Plan Development ☐ Other (Describe) _____

This is notification that I have been selected by the above-named individual to provide necessary vocational rehabilitation services to help that individual return to work.

Vocational Rehabilitation Specialist Signature	Date Case Opened
Preparer Printed Name	Date Case Prepared